License Application

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Midwife Liaison Committee
P.O. Box 46018
124 Halsey Street, 6th Floor, Newark, NJ 07101

Midwife Liaison Committee
Application Check-List

Use this checklist to determine whether you have complied with all requirements. Once your application is received a file will be started and you will be notified if any documents are missing. .

- ☐ One (1) passport size photograph
- ☐ $125.00 application fee made payable to the **State of New Jersey**. *(non-refundable)*
- ☐ $50.00 additional application fee made payable to the State of New Jersey **ONLY** if you are also applying for Prescriptive Authorization *(non-refundable)*
- ☐ Copy of birth certificate, passport or proof of immigration status.
- ☐ Completed and notarized application
- ☐ Official midwifery education transcripts requested to be sent directly to the Committee office at P.O. Box 46018, 124 Halsey Street, 6th Floor, Newark, NJ 07101
- ☐ Official verification of certification status to be sent from either: American Midwife Certification Board (AMCB), American College of Nurse Midwives Certification Council (ACC), or the North American Registry of Midwives (NARM), as applicable. Form should be sent directly to the Committee office at P.O. Box 46018, 124 Halsey Street, 6th Floor, Newark, NJ 07101
- ☐ If you are applying for prescriptive authorization and completed your pharmacology education in a program separate from your midwifery education., program should complete the verification form attached to the application.
- ☐ Completed and notarized Certification and Authorization Form for a Criminal History Background Check (CHBC). Instructions for the completion of a CHBC will be provided once your application is received. If you have been fingerprinted by another New Jersey licensing board (such as the Board of Nursing), please read the instructions carefully. You do not have to be fingerprinted again! If your fingerprints were completed within the last six months, your federal background check does not need to be repeated and you should not submit an additional check for $33.00.
- ☐ Resume/Curriculum Vitae
- ☐ Verification of License sent to the Board office from any/all states in which you hold any professional license. Copies of licenses are NOT considered adequate verification for this purpose. You may use the attached verification form or the issuing state may have their own form.
- ☐ Affiliated Physician Form – send in with your application or submit once you have obtained employment
- ☐ Please make note that certain responses to questions may require you to submit additional explanatory information. Please attach any explanations to your application. Please reference the question #.

Staple a clear, full-face passport - style photograph (2"x 2") of your head and shoulders, taken within the past six months.

A photo is required with each application.

For office use only

Application number: _____

License number: _____

License Issue Date: _____

New Jersey Office of the Attorney General
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P.O. Box 46018
124 Halsey Street, 6th Floor
Newark, New Jersey 07101
(973) 273-8009

Official Application for Midwife Licensure

Date: _____

I am applying for a license as a:

- ☐ Certified Nurse Midwife
- ☐ Certified Nurse Midwife with Prescriptive Authority
- ☐ Certified Professional Midwife
- ☐ Certified Midwife

A nonrefundable application filing fee of $125 in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. If you are also applying for prescriptive authority, a separate application fee of $50.00 is required. (Applicants should understand that if the fees are paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure process will be delayed until the fees are paid.)

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name: _____ (_____)
   First Middle Last Maiden Name

2. Address: _____
   Street City State Zip County

   _____ _____
   Telephone Number E-mail address

3. Date of Birth: _____ Place of Birth: _____
   Month/Day/Year City/State/Country

4. Social Security Number: _____/_____/_____

Privacy Act Notice: You are hereby notified pursuant to the Privacy Act (5 U.S.C. § 552a (note)(b))that disclosure of your Social Security number in this application form is voluntary. The Board of Medical Examiners may use your Social Security number for the following: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Board or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings. Pursuant to N.J.S.A. 2A:17-56.44(e) of the NJ Child Support Enforcement Law and N.J.S.A. 54:50-25 of the NJ Taxation Law, the Board of licensing agency to which this form is submitted is required to obtain your Social Security number and/or federal taxpayer identification number, and where neither is possessed, the reason for not having such a number. The Board is further obligated to provide these identifying numbers to the Director of Taxation and the Probation Division or other agency responsible for child support enforcement.

I _____ ☐ consent ☐ do not consent to the use of my Social Security number for any of the purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action in inference will be taken or drawn.

5. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are an American citizen, please enclose a copy of your birth certificate or U.S. Passport. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status. Note status here:_____

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

6. Midwifery Education

_____
Name and address of institution

Date Enrolled ____/____/_____ ☐ Completed Program on ____/____/_____

OFFICIAL TRANSCRIPT FROM A MIDWIFERY PROGRAM ACCREDITED BY THE AMERICAN COLLEGE OF NURSE MIDWIVES (ACNM) OR THE MIDWIFERY EDUCATION ACCREDITATION COUNCIL (MEAC) OR THEIR SUCCESSOR ORGANIZATIONS, MUST BE FORWARDED DIRECTLY TO THE BOARD OFFICE.

7. Certification Examinations

Please indicate Certification Examination taken: ☐ ACNM/AMCB ☐ ACC ☐ NARM

Date of Certification: _____

AN OFFICIAL NOTARIZED COPY ATTESTING TO AN APPLICANT'S CERTIFIED STATUS MUST BE PROVIDED BY THE CERTIFICATION ORGANIZATION DIRECTLY TO THE BOARD OFFICE.

8. Prescriptive Authorization – New Jersey requires that an applicant complete pharmacology education within two years from the date of application (or as part of your midwifery education), or hold a current prescriptive authorization in another State. If you are not applying for prescriptive authorization, skip this question and move on to question #9.

Do you hold prescriptive authorization in any other State? ☐Yes ☐ No

If the answer to this question is "Yes," the issuing state must verify that the prescriptive authorization is current and in good standing. List State here:_____

Pharmacology Education (complete this section if your pharmacology education was completed in a program other than your midwifery program). Program must be no less than 30 contact hours and be accredited college or university based or affiliated.

_____
Name and address of institution

Date Enrolled ____/____/_____ ☐ Completed Program on ____/____/_____

9. Do you currently hold, or have you ever held a professional license of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If you have answered "Yes" to question #8 and/or #9 please indicate the state(s) below and submit a verification form (attached) to each state. The verification form must be sent directly from the state(s) to the NJ Midwife Liaison Committee. In lieu of completing the enclosed form, the Committee will accept a State-issued verification letter.

State that issued the license	***License Number***	***Date issued/expired***	***Status***

10. Please submit a resumé or curriculum vitae listing all activities including periods of unemployment beginning with graduation from high school through the present time.

11. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐YES ☐NO
If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual payment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for payment of your student loan.

All questions must be answered

12. Have you ever been arrested, charged with and/or been convicted of any crimes or offenses (including petty offenses) as an adult or juvenile, excluding motor vehicles offenses, except driving while intoxicated? ☐ YES ☐ NO

13. Have you ever been convicted of any crime or offense under any circumstances such as, but not limited to, a plea of guilty, Non Vult, Nolo Contendere, No Contest, etc., or a finding of judge or jury? ☐ YES ☐ NO

14. Have you ever been denied a license to practice a profession or eligibility to sit for a licensing exam in this state, any other state, or foreign country, or have you been permitted to withdraw an application for licensure while under investigation? ☐ YES ☐ NO

15. Have you ever been the defendant in a malpractice suit? ☐ YES ☐ NO

a. Have you ever been denied malpractice insurance coverage? ☐ YES ☐ NO
b. Have you ever had any practice curtailments? ☐ YES ☐ NO
c. Have you ever been assessed a surcharge? ☐ YES ☐ NO
d. Has limitation ever been required? ☐ YES ☐ NO
e. Have you ever been required to have office monitoring? ☐ YES ☐ NO

16. Is there any action pending against you now, or in the past, whether for a crime of offense or any action by a regulatory agency, such as but not limited to professional licensing agencies, Medicaid, Medicare or any other government agency? ☐ YES ☐ NO

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS, #12 THROUGH #16, YOU MUST PROVIDE THE FOLLOWING:

- ***A WRITTEN EXPLANATION OF THE INCIDENT.***
- ***COURT OR AGENCY RECORDS***

FOR THE PURPOSES OF THE FOLLOWING QUESTIONS, #17 THROUGH #24, THE FOLLOWING PHRASES OR WORDS HAVE THE FOLLOWING MEANINGS:

Ability to practice midwifery is to be construed to include all of the following:

A. The cognitive capacity to make appropriate midwifery or clinical diagnoses, exercise reasoned midwifery judgments and to learn and keep abreast of midwifery developments; and

B. The ability to communicate those judgments and midwifery information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

C. The physical capability to perform midwifery tasks such a physical examination and midwifery procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"***Medical condition***" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"***Chemical substances***" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"***Currently***" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"***Illegal use of controlled dangerous substances***" means the use of controlled dangerous substances obtained illegally (i.e. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

You have a right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure will be processed if you claim the Fifth Amendment privilege against self incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question which you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. N.J.S.A. 45:1-20.

17. Do you have a medical condition which in any way impairs or limits your ability to practice midwifery with reasonable skill and safety? ☐Yes ☐No If yes, please explain.

_____

_____

18. Does your use of chemical substance(s) in any way impair or limit your ability to practice midwifery with reasonable skill and safety? ☐Yes ☐No ☐Not Applicable If yes, please explain.

_____

_____

19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?
☐Yes ☐No ☐Not Applicable If yes, please explain.

** If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____

_____

20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?
☐Yes ☐No ☐Not Applicable If yes, please explain.

_____

_____

21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐Yes ☐No If yes, please explain.

_____

_____

22. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐Yes ☐No

If you answered "Yes" to question 22, are you currently participating, or have you within the past two (2) years participated, in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

_____

_____

AUTHORIZATION

I _____, hereby authorize all hospitals*, institutions* or organizations, my references, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the New Jersey State Board of Medical Examiners/Midwife Liaison Committee any information, files or records requested by the Board. I further authorize the New Jersey State Board of Medical Examiners/Midwife Liaison Committee to release to the organizations, individuals and groups listed above any information.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare under penalty or perjury that my answers and all statements made by me herein are true and correct and further declare that I am the person referred to in the above application. Should I furnish any false information in this application, I hereby agree that such an act shall constitute cause for denial, suspension or revocation of my license to practice midwifery in the State of New Jersey.

I HAVE READ THE ABOVE
AND UNDERSTAND SAME

_____ _____
Applicant's Name (Please Print or type) Date

_____
Signature of applicant

Sworn to before me this _____

day of _____, 20_____

_____
Notary Public

Affix Seal Here

- relating to clinical or post-graduate programs

If you require additional space on which to answer any of the preceding questions you may attach your response to the last page of this application, having made sure that you print or type your name to each attachment.

CHILD SUPPORT

Please certify under penalty of perjury, the following questions:

23.	Do you currently have a child-support obligation?	☐ YES	☐ NO
	If yes, are you in arrears in payment of said obligation?	☐ YES	☐ NO
	If yes, does the arrears match or exceed the total amount payable for the past six months?	☐ YES	☐ NO
24.	Have you failed to provide any court ordered health insurance coverage during the past six months?	☐ YES	☐ NO
25.	Have you failed to respond to a subpoena relating to either a paternity or child supporting proceeding?	☐ YES	☐ NO
26.	Are you the subject of a child support related warrant?	☐ YES	☐ NO

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions 25 through 28 will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____ _____

Applicant's Name (Please Print or type) Date

_____

Signature of applicant

Affix Seal Here

Sworn to before me this _____

day of _____ , 20_____

_____

Notary Public

New Jersey Office of the Attorney General
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New Jersey State Board of Medical Examiners
Midwife Liaison Committee
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Verification of State License

A separate form must be used for each state.
(This form may be reproduced.)

Name of Applicant: _____
First Middle Last

The above-named applicant is a licensee of the State of _____ and was issued license number _____ on _____.
Month Day Year

The applicant was licensed by:

☐ Examination

☐ Endorsement/Reciprocity from the State of _____.

The license status is:

☐ Current and in good status expiring on _____.
Date

☐ Inactive/Expired on _____.
Date

☐ Revoked or Suspended

☐ Other (please attach explanation)

This licensee ☐ does ☐ does not hold prescriptive authority in this State.

The licensee ☐ does ☐ does not have a record of disciplinary history with this agency. Attach additional information if applicable.

CERTIFICATION

I hereby certify that to the best of my knowledge and belief, the foregoing is a true statement of the record of the individual named on this form.

_____
Name of Board

_____
Name of person completing this form

(Board Seal)

_____
Title

_____
Signature

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Verification of Pharmacology Education

Name of Applicant: _____
First Middle Last

Course title: _____

Location: _____

Hours completed:_____

Dates: _____

It is hereby certified that the above named Certified Nurse Midwife has successfully completed a minimum educational program of at least 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in the course identified above on the date shown. This individual received full credit from this organization for the course shown.

_____
Signature

_____
Title of Certifying Official (Seal of Orgnaization)

_____
Date signed

THIS FORM MUST REFLECT THE SEAL OF THE ORGANIZATION SPONSORING THE COURSE. A COPY OF COURSE SYLLABUS MUST BE ATTACHED TO THE FORM UNLESS THE COURSE HAS BEEN PREVIOUSLY APPROVED BY THE COMMITTEE.

RETURN THE FORM TO THE ADDRESS NOTED ABOVE.

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Affiliated Physician Form

In addition to the requirements for licensure, each applicant must establish a written affiliation agreement with a New Jersey licensed physician who holds hospital privileges in operative obstetrics/gynecology. The agreement shall set forth written clinical guidelines that will outline the licensee's scope of practice. The specific requirements are set forth in Committee regulations contained at N.J.A.C. 13:35-2A.6.

Name of Midwife:_____

Physician Name:_____

License Number:_____

Address:_____

_____

_____

Effective Date of Agreement:_____

_____	_____
Signature of Midwife	**Signature of Physician**
_____	_____
Print Name of Midwife	**Print Name of Physician**

Official Use Only
☐ Dual License
License Type 1

Applicant's Number

License Type 2

Applicant's Number

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Midwives, Liaison Committee
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Newark, New Jersey 07101
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Official Use Only

☐ Resubmit

Board or Committee

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs**, you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this background check will be $28.25. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date